The Ethics of Suicide

BY THOMAS S. SZASZ, M.D.

In 1967, an editorial in The Journal of the American Medical Association declared that "The contemporary physician sees suicide as a manifestation of emotional illness. Rarely does he view it in a context other than that of psychiatry" [March 6]. It was thus implied, the emphasis being the stronger for not being articulated, that to view suicide in this way is at once scientifically accurate and morally uplifting. I submit that it is neither; that, instead, this perspective on suicide is both erroneous and evil: erroneous because it treats an act as if it were a happening; and evil, because it serves to legitimize psychiatric force and fraud by justifying it as medical care and treatment.

Before going further, I should like to distinguish three fundamentally different concepts and categories that are combined and confused in most discussions of suicide. They are: 1. Suicide proper, or so-called successful suicide; 2. Attempted, threatened, or so-called unsuccessful suicide; and 3. The attribution by someone (typically a psychiatrist) to someone else (now called a "patient") of serious (that is, probably successful) suicidal intent. The first two concepts refer to acts by an actually or ostensibly suicidal person; the third refers to the claim of an ostensibly normal person about someone else's suicide-proneness.

I believe that, generally speaking, the person who commits suicide intends to die; whereas the one who threatens suicide or makes an unsuccessful attempt at it intends to improve his life, not to terminate it. (The person who makes claims about someone else's suicidal intent does so usually in order to justify his efforts to control that person.)

Put differently, successful suicide is generally an expression of an individual's desire for greater autonomy—in particular, for self-control over his
own death; whereas unsuccessful suicide is generally an expression of an individual's desire for more control over others—in particular, for compelling persons close to him to comply with his wishes. Although in some cases there may be legitimate doubt about which of these conditions obtains, in the majority of instances where people speak of "suicide" or "attempted suicide," the act falls clearly into one or the other group.

In short, I believe that successful and unsuccessful suicide constitute radically different acts and categories, and hence cannot be discussed together. Accordingly, I have limited the scope of this essay to suicide proper, with occasional references to attributions of suicidal intent. (The ascription of suicidal intent is, of course, a very different sort of thing from either successful or unsuccessful suicide. Since psychiatrists use it as if it designated a potentially or probably fatal "condition," it is sometimes necessary to consider this concept together with the phenomenon of suicide proper.)

It is difficult to find "responsible" medical or psychiatric authority today that does not regard suicide as a medical, and specifically as a mental health, problem.

For example, Ilza Veith, the noted medical historian, writing in *Modern Medicine* [August 11, 1969], asserts that "... the act [of suicide] clearly represents an illness. . . ."

Bernard R. Shochet, a psychiatrist at the University of Maryland, offers a precise description of the kind of illness it is. "Depression," he writes, "is a serious systemic disease, with both physiological and psychological concomitants, and suicide is a part of this syndrome." And he articulates the intervention he feels is implicit in this view: "If the patient's safety is in doubt, psychiatric hospitalization should be insisted on."

Harvey M. Schein and Alan A. Stone, both psychiatrists at the Harvard Medical School, are even more explicit about the psychiatric coercion justified, in their judgment, by the threat of suicide. "Once the patient's suicidal thoughts are shared," they write, "the therapist must take pains to make clear to the patient that he, the therapist, considers suicide to be a maladaptive action, irreversibly counter to the patient's sane interests and goals; that he, the therapist, will do everything [emphasis mine, T.S.] he can to prevent it; and that the potential for such an action arises from the patient's illness. It is equally essential that the therapist believe in the professional stance; if he does not he should not be treating the patient within the delicate human framework of psychotherapy."**

---


Schein and Stone do not explain why the patient's confiding in his therapist to the extent of communicating his suicidal thoughts to him should *ipso facto* deprive the patient from being the arbiter of his own best interests. The thrust of their argument is prescriptive rather than logical. They seek to justify depriving the patient of a basic human freedom—the freedom to grant or withhold consent for treatment: “The therapist must insist that patient and physician—*together* [italics in the original]—communicate the suicidal potential to important figures in the environment, both professional and family. . . . Suicidal intent must not be part of therapeutic confidentiality.” And further on they write: “Obviously this kind of patient must be hospitalized. . . . The therapist must be prepared to step in with hospitalization, with security measures, and with medication . . . .”

Schein and Stone thus suggest that the “suicidal” patient should have the right to choose his therapist; and that he should have the right to agree with his therapist and follow the latter’s therapeutic recommendation (say, for hospitalization). At the same time, they insist that if “suicidal” patient and therapist disagree on therapy, then the patient should not have the right to disengage himself from the first therapist and choose a second—say, one who would consider suicidal intent a part of therapeutic confidentiality.

Many other psychiatric authorities could be cited to illustrate the current unanimity on this view of suicide.

Lawyers and jurists have eagerly accepted the psychiatric perspective on suicide, as they have on nearly everything else. An article in the *American Bar Association Journal* [September 1968] by R. E. Schulman, who is both a lawyer and a psychologist, is illustrative.

Schulman begins with the premise that “No one in contemporary Western society would suggest that people be allowed to commit suicide as they please without some attempt to intervene or prevent such suicides. Even if a person does not value his own life, Western society does value everyone's life.”

But I should like to suggest, as others have suggested before me, precisely what Schulman claims no one would suggest. Furthermore, if Schulman chooses to believe that Western society—which includes the United States with its history of slavery, Germany with its history of National Socialism, and Russia with its history of Communism—really “values everyone’s life,” so be it. But to accept this assertion as true is to fly in the face of the most obvious and brutal facts of history.

When a person decides to take his life, and when a physician decides to frustrate him in this action, the question arises: Why should the physician do so?

Conventional psychiatric wisdom answers: Because the suicidal person
(now called "patient" for proper emphasis) suffers from a mental illness whose symptom is his desire to kill himself; it is the physician's duty to diagnose and treat illness: *ergo*, he must prevent the "patient" from killing himself and, at the same time, must "treat" the underlying "disease" that "causes" the "patient" to wish doing away with himself. This looks like an ordinary medical diagnosis and intervention. But it is not. What is missing? Everything. This hypothetical, suicidal "patient" is not ill: he has no demonstrable bodily disorder (or if he does, it does not "cause" his suicide); he does not assume the sick role; he does not seek medical help. In short, the physician uses the rhetoric of illness and treatment to justify his forcible intervention in the life of a fellow human being—often in the face of explicit opposition from his so-called "patient."

I do not doubt that attempted or successful suicide may be exceedingly disturbing for persons related to, acquainted with, or caring for the ostensible "patient." But I reject the conclusion that the suicidal person is, *ipso facto*, disturbed, that being disturbed equals being mentally ill, and that being mentally ill justifies psychiatric hospitalization or treatment. I have developed my reasons for this elsewhere, and need not repeat them here.* For the sake of emphasis, however, let me state that I consider counseling, persuasion, psychotherapy, or any other voluntary measure, especially for persons troubled by their own suicidal inclinations and seeking such help, unobjectionable, and indeed generally desirable, interventions. However, physicians and psychiatrists are usually not satisfied with limiting their help to such measures—and with good reason: from such assistance the individual may gain not only the desire to live, but also the strength to die.

But we still have not answered the question: Why should a physician frustrate an individual from killing himself? As we saw, some psychiatrists answer: Because the physician values the patient's life, at least when the patient is suicidal, more highly than does the patient himself. Let us examine this claim. Why should the physician, often a complete stranger to the suicidal patient, value the patient's life more highly than does the patient himself? He does not do so in medical practice. Why then should he do so in psychiatric practice, which he himself insists is a form of medical practice? Let us assume that a physician is confronted with an individual suffering from diabetes or heart failure who fails to take the drugs prescribed for his illness. We know that this often happens, and that when it does the patient may become disabled and die prematurely. Yet it would be absurd for a physician to consider, much less to attempt, taking over the conduct of such a patient's life, confining him in a hospital against his will in order to treat his disease. Indeed, any attempt to do so would bring the physician into conflict with both the civil and the criminal law. For, significantly, the law recognizes the medical patient's autonomy despite the fact that, unlike

---

the suicidal individual, he suffers from a real disease; and despite the fact that, unlike the nonexistent disease of the suicidal individual, his illness is often easily controlled by simple and safe therapeutic procedures.

Nevertheless, the threat of alleged or real suicide, or so-called dangerousness to oneself, is everywhere considered a proper ground and justification for involuntary mental hospitalization and treatment. Why should this be so?

Let me suggest what I believe is likely to be the most important reason for the profound antisuicidal bias of the medical profession. Physicians are committed to saving lives. How, then, should they react to people who are committed to throwing away their lives? It is natural for people to dislike, indeed to hate, those who challenge their basic values. The physician thus reacts, perhaps "unconsciously" (in the sense that he does not articulate the problem in these terms), to the suicidal patient as if the patient had affronted, insulted, or attacked him: The physician strives valiantly, often at the cost of his own well-being, to save lives; and here comes a person who not only does not let the physician save him, but, horribile dictu, makes the physician an unwilling witness to that person's deliberate self-destruction. This is more than most physicians can take. Feeling assaulted in the very center of their spiritual identity, some take to flight, while others fight back.

Some non-psychiatric physicians will thus have nothing to do with suicidal patients. This explains why many people who end up killing themselves have a record of having consulted a physician, often on the very day of their suicide. I surmise that these persons go in search of help, only to discover that the physician wants nothing to do with them. And, in a sense, it is right that it should be so. I do not blame the doctors. Nor do I advocate teaching them suicide prevention—whatever that might be. I contend that because physicians have a relatively blind faith in their life-saving ideology—which, moreover, they often need to carry them through their daily work—they are the wrong people for listening and talking to individuals, intelligently and calmly, about suicide. So much for those physicians who, in the face of the existential attack which they feel the suicidal patient launches on them, run for their lives. Let us now look at those who stand and fight back.

Some physicians (and other mental health professionals) declare themselves not only ready and willing to help suicidal patients who seek assistance, but all persons who are, or are alleged to be, suicidal. Since they, too, seem to perceive suicide as a threat, not just to the suicidal person's physical survival but to their own value system, they strike back and strike back hard. This explains why psychiatrists and suicidologists resort, apparently with a perfectly clear conscience, to the vilest methods: they must believe that their lofty ends justify the basest means. Hence the prevalent use of force and fraud in suicide prevention. The consequence of this kind of interaction between physician and "patient" is a struggle for power. The patient is at least honest about what he wants: to gain control over his life and death—by being the agent of his own demise. But the (suicide-prevent-
ing) psychiatrist is completely dishonest about what he wants: he claims that he only wants to help his patient, while actually he wants to gain control over the patient’s life in order to save himself from having to confront his doubts about the value of his own life. Suicide is medical heresy. Commitment and electro-shock are the appropriate psychiatric-inquisitorial remedies for it.

In the West, opposition to suicide, like opposition to contraception and abortion, rests on religious grounds. According to both the Jewish and Christian religions, God created man, and man can use himself only in the ways permitted by God. Preventing conception, aborting a pregnancy, or killing oneself are, in this imagery, all sins: each is a violation of the laws laid down by God, or by theological authorities claiming to speak in His name.

But modern man is a revolutionary. Like all revolutionaries, he likes to take away from those who have and to give to those who have not, especially himself. He has thus taken Man from God and given him to the State (with which he often identifies more than he knows). This is why the State gives and takes away so many of our rights, and why we consider this arrangement so “natural.” (Hence the linguistic abomination of referring to the abolition of prohibitions, say against abortion or off-track betting, as the “legalizing” of these acts.)

But this arrangement leaves suicide in a peculiar moral and philosophical limbo. For if a man’s life belongs to the State (as it formerly belonged to God), then surely suicide is the taking of a life that belongs not to the taker but to everyone else.

The dilemma of this simplistic transfer of body-ownership from God to State derives from the fundamental difference between a religious and secular world view, especially when the former entails a vivid conception of a life after death, whereas the latter does not (or even emphatically repudiates it). More particularly, the dilemma derives from the problem of how to punish successful suicide? Traditionally, the Roman Catholic Church punished it by depriving the suicide of burial in consecrated ground. As far as I know, this practice is now so rare in the United States as to be practically nonexistent. Suicides are given a Catholic burial, as they are routinely considered having taken their lives while insane.

The modern State, with psychiatry as its secular-religious ally, has no comparable sanction to offer. Could this be one of the reasons why it punishes so severely—so very much more severely than did the Church—the unsuccessful suicide? For I consider the psychiatric stigmatization of people as “suicidal risks” and their incarceration in psychiatric institutions a form of punishment, and a very severe one at that. Indeed, although I cannot support this claim with statistics, I believe that accepted psychiatric meth-
ods of suicide prevention often aggravate rather than ameliorate the suicidal person’s problems. As one reads of the tragic encounters with psychiatry of people like James Forrestal, Marilyn Monroe, or Ernest Hemingway, one gains the impression that they felt demeaned and deeply hurt by the psychiatric indignities inflicted on them, and that, as a result of these experiences, they were even more desperately driven to suicide. In short, I am suggesting that coerced psychiatric interventions may increase, rather than diminish, the suicidal person’s desire for self-destruction.

But there is another aspect of the moral and philosophical dimensions of suicide that must be mentioned here. I refer to the growing influence of the resurgent idea of self-determination, especially the conviction that men have certain inalienable rights. Some men have thus come to believe (or perhaps only to believe that they believe) that they have a right to life, liberty, and property. This makes for some interesting complications for the modern legal and psychiatric stand on suicide.

This individualistic position on suicide might be put thus: A man’s life belongs to himself. Hence, he has a right to take his own life, that is, to commit suicide. To be sure, this view recognizes that a man may also have a moral responsibility to his family and others, and that, by killing himself, he reneges on these responsibilities. But these are moral wrongs that society, in its corporate capacity as the State, cannot properly punish. Hence the State must eschew attempts to regulate such behavior by means of formal sanctions, such as criminal or mental hygiene laws.

The analogy between life and other types of property lends further support to this line of argument. Having a right to property means that a person can dispose of it even if in so doing he injures himself and his family. A man may give away, or gamble away, his money. But, significantly, he cannot—our linguistic conventions do not allow it—to steal from himself. The concept of theft requires at least two parties: one who steals and another from whom is stolen. There is no such thing as “self-theft.” The term “suicide” blurs this very distinction. The etymology of this term implies that suicide is a type of homicide, one in which criminal and victim are one and the same person. Indeed, when a person wants to condemn suicide he calls it “self-murder.” Schulman, for example, writes: “Surely, self-murder falls within the province of the law.”

History does repeat itself. Until recently, psychiatrists castigated as sick and persecuted those who engaged in self-abuse (that is, masturbation);* now they castigate as sick and persecute those who engage in self-murder (that is, suicide).

The suicidologist has a literally schizophrenic view of the suicidal person: He sees him as two persons in one, each at war with the other. One-half of the patient wants to die; the other half wants to live. The former, says the suicidologist, is wrong; the latter is right. And he proceeds to pro-

tect the latter by restraining the former. However, since these two people are, like Siamese twins, one, he can restrain the suicidal half only by restraining the whole person.

The absurdity of this medical-psychiatric position on suicide does not end here. It ends in extolling mental health and physical survival over every other value, particularly individual liberty.

In regarding the desire to live as a legitimate human aspiration, but not the desire to die, the suicidologist stands Patrick Henry’s famous exclamation, “Give me liberty, or give me death!” on its head. In effect, he says: “Give him commitment, give him electroshock, give him lobotomy, give him life-long slavery, but do not let him choose death!” By so radically invalidating another person’s (not his own!) wish to die, the suicide-preventer redefines the aspiration of the Other as not an aspiration at all: The wish to die thus becomes something an irrational, mentally diseased being displays, or something that happens to a lower form of life. The result is a far-reaching infantilization and dehumanization of the suicidal person.

For example, Phillip Solomon writes in the *Journal of the American Medical Association* [January 30, 1967], that “We [physicians] must protect the patient from his own [suicidal] wishes.” While to Edwin Schneidman, “Suicide prevention is like fire prevention...” [*Preventing Suicide,* *Bulletin of Suicidology* (1968).] Solomon thus reduces the would-be suicide to the level of an unruly child, while Schneidman reduces him to the level of a tree! In short, the suicidologist uses his professional stance to illegitimize and punish the wish to die.

There is, of course, nothing new about any of this. Do-gooders have always opposed personal autonomy or self-determination. In “Amok,” written in 1931, Stefan Zweig put these words into the mouth of his protagonist: “Ah, yes, ‘It’s one’s duty to help.’ That’s your favorite maxim, isn’t it? ... Thank you for your good intentions, but I’d rather be left to myself. ... So I won’t trouble you to call, if you don’t mind. Among the ‘rights of man’ there is a right which no one can take away, the right to croak when and where and how one pleases, without a ‘helping hand.’”*

But this is not the way the scientific psychiatrist and suicidologist sees the problem. He might agree (I suppose) that, in the abstract, man has the right Zweig claimed for him. But, in practice, suicide (so he says) is the result of insanity, madness, mental illness. Furthermore, it makes no sense to say that one has a right to be mentally ill, especially if the illness is one that, like typhoid fever, threatens the health of other people as well. In short, the suicidologist’s job is to try to convince people that wanting to die is a disease.

This is how Ari Kiev, director of the Cornell Program in Social Psychiatry and its suicide prevention clinic, does it: ‘We say [to the patient], look, you have a disease, just like the Hong Kong flu. Maybe you’ve got the

---

*“Amok,” in *The Royal Game* (1944), p. 137.*
Hong Kong depression. First, you’ve got to realize you are emotionally ill. . . . Most of the patients have never admitted to themselves that they are sick. . . .” [The New York Times (February 9, 1969), p. 96.]

This pseudo-medical perspective is then used to justify psychiatric deception and coercion of the crudest sort.

Here is how, according to the Wall Street Journal, the Los Angeles Suicide Prevention Center operates. A man calls and says he is about to shoot himself. The worker asks for his address. The man refuses to give it. “‘If I pull it [the trigger] now I’ll be dead,’ he [the caller] said in a muffled voice. ‘And that’s what I want.’ Silently but urgently, Mrs. Whitbook [the worker] has signalled a co-worker to begin tracing the call. And now she worked to keep the man talking. . . . An agonizing 40 minutes passed. Then she heard the voice of a policeman come on the phone to say the man was safe.” [(March 6, 1969), p. 1.]

But surely, if this man was able to call the Suicide Prevention Center, he could have, had he wanted to, called for a policeman himself. But he did not. He was thus deceived by the Center in the “service” he got.

I understand that this kind of deception is standard practice in suicide prevention centers, though it is often denied that it is. A report about the Nassau County Suicide Prevention Service corroborates the impression that when the would-be suicide does not cooperate with the suicide-prevention authorities, he is confined involuntarily. “When a caller is obviously suicidal,” we are told, “a Meadowbrook ambulance is sent out immediately to pick him up.” [Medical World News (July 28, 1967), p. 17.]

One more example of the sort of thing that goes on in the name of suicide prevention should suffice. It is a routine story from a Syracuse newspaper. The gist of it is all in one sentence: “A 28-year-old Minoa [a Syracuse suburb] man was arrested last night on a charge of violation of the Mental Hygiene Law, after police authorities said they spent two hours looking for him in the Minoa woods.” [Syracuse Post Standard, (September 29, 1969), p. 10.] But this man has harmed no one; his only “offense” was that someone claimed he might harm himself. Why, then, should the police look for, much less arrest, him? Why not wait until he returns? Or why not look, offer help, but avoid arrest and coerced psychiatry?

These are rhetorical questions. For our answers to them depend on and reflect our concepts of what it means to be a human being.

I submit, then, that the crucial contradiction about suicide viewed as an illness whose treatment is a medical responsibility is that suicide is an action but is treated as if it were a happening. As I showed else-
where, this contradiction lies at the heart of all so-called mental illnesses or psychiatric problems. However, it poses a particularly acute dilemma for suicide, because suicide is the only fatal “mental illness.”

Before concluding, I should like to restate briefly my views on the differences between diseases and desires, and show that by persisting in treating desires as diseases, we only end up treating man as a slave.

Let us take, as our paradigm case of illness, a skier who takes a bad spill and fractures an ankle. This fracture is something that has happened to him. He has not intended it to happen. (To be sure, he may have intended it; but that is another case.) Once it has happened, he will seek medical help and will cooperate with medical efforts to mend his broken bones. In short, the person and his fractured ankle are, as it were, two separate entities, the former acting on the latter.

Let us now consider the case of the suicidal person. Such a person may also look upon his own suicidal inclination as an undesired, almost alien, impulse and seek help to combat it. If so, the ensuing arrangement between him and his psychiatrist is readily assimilated to the standard medical model of treatment: the patient actively seeks and cooperates with professional efforts to remedy his “condition.”

But as we have seen this is not the only way, nor perhaps the most important way, that the game of suicide prevention is played. It is accepted medical and psychiatric practice to treat persons for their suicidal desires against their will. And what exactly does this mean? Something quite different from that to which it is often analogized, namely the involuntary (or non-voluntary) treatment of a bodily illness. For a fractured ankle can be set whether or not a patient consents to its being set. That is because setting a fracture is a mechanical act on the body. But a threatened suicide cannot be prevented whether or not the “patient” consents to its being prevented. That is because, suicide being the result of human desire and action, suicide prevention is a political act on the person. In other words, since suicide is an exercise and expression of human freedom, it can be prevented only by curtailing human freedom. This is why deprivation of liberty becomes, in institutional psychiatry, a form of treatment.

In the final analysis, the would-be suicide is like the would-be emigrant: both want to leave where they are and move elsewhere. The suicide wants to leave life and embrace death. The emigrant wants to leave his homeland and settle in another country.

Let us take this analogy seriously. It is much more faithful to the facts than is the analogy between suicide and illness. A crucial characteristic that distinguishes open from closed societies is that people are free to leave the former but not the latter. The medical profession’s stance toward suicide is

---

thus like the Communists' toward emigration: the doctors insist that the would-be suicide survive, just as the Russians insist that the would-be emigrant stay home.

Whether those who so curtail other people's liberties act with complete sincerity, or with utter cynicism, hardly matters. What matters is what happens: the abridgment of individual liberty, justified, in the case of suicide prevention, by psychiatric rhetoric; and, in the case of emigration prevention, by political rhetoric.

In language and logic we are the prisoners of our premises, just as in politics and law we are the prisoners of our rulers. Hence we had better pick them well. For if suicide is an illness because it terminates in death, and if the prevention of death by any means necessary is the physician's therapeutic mandate, then the proper remedy for suicide is indeed liberticide.

MENSTRUATION

BY ROSMARIE WALDROP

My appetite's for waking dreams
chill crystals in the dormant clouds
pebble seeds
like Flaubert that ox of art
devoting years to the accumulation
of details he thought worth nothing
next to a bare wall

I insist on living with words
of a tongue that's not my mother's
giving vicarious birth to a vicarious existence

while each month my womb cries
till its mouth is swollen
and prepares for pregnancy with spongy warmth and energy congested with secretion
and red rot is carried back to the earth